MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

October 13, 2009

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JOHN A. LIVERATTI, CHIEF OF COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATIONS

Changes to this chapter are the result of the recommendations of the Drug Use Review (DUR) Board meetings of October 30, 2008 and April 30, 2009. Pursuant to NRS 422.403, the DUR Board manages step therapy and prior authorizations for prescription drugs. The DUR Board currently consists of eight members (four physicians and four pharmacists) and is appointed by the Director of the Department of Health and Human Services.

On October 30, 2008, the DUR board discussed and approved criteria for Omalizumab (Xolair®). On April 30, 2009, the DUR Board specifically discussed and took action to establish criteria and quantity limits for Lidoderm Patches®. The DUR board also took action by approving quantity limits on narcotic/acetaminophen combination agents. These miscellaneous changes are based on updated policies and procedures. Changes are effective upon approval of the public hearing.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 31/09 CHAPTER 1200 - PRESCRIBED DRUGS	**MTL 21/03, 02/07** CHAPTER 1200 – PRESCRIBED DRUGS
Sec. 1203.1A.6.b	Deleted "A copy of the Explanation of Benefits (EOB) from the other third party payer must be attached to the claim."
Sec. 1203.1A.6.c Added "rejected or denied"	Deleted "returned"
Added "of service."	Deleted "on the return form."

Sec. 1203.1A.6.f

Added ","

Added "fax, or via FHSC's Web PA,"

Deleted "or other telecommunication device (fax)"

Sec. 1203.1B.2.c

Added "Board" twice in paragraph

Added "drug"

Added "clients"

Deleted "committee" twice in paragraph

Deleted "ambulatory"

Deleted "patients,"

Sec. 1203.1B.2.d

Added "Please refer to Medicaid Services Manual Chapter 100, Section 101.3 for information on Medicaid eligibility, eligibility verification and the Eligibility Verification System (EVS)."

Deleted "Eligibility for Medicaid services is verified by possession of a Medicaid card valid for the current month."

Sec. 1203.1B.2d.1

Added "Medicaid recipients are issued a plastic identification card upon approval of benefits but it does not guarantee eligibility for benefits."

Deleted "Medicaid cards printed "A" or "M" mean Qualified Medicare Beneficiary (QMB); "A" is eligible for full Medicaid Services; "M" is eligible only for Medicare deductible and co-insurance, no other Medicaid Services. A recipient card marked with a "P" is eligible only for pregnancy-related services, no others."

Sec. 1203.1B.2.d.2

Added "E"

Added "calling FHSC's Automated Response System (ARS) at (800) 942-6511."

Deleted "When patients claim Medicaid eligibility but do not have a computer generated Medicaid card, e"

Deleted "the Eligibility Verification System ( )"

Deleted "contacting"

Deleted "the appropriate Division of Welfare and Support Services District Office (see Section 1205)."

Sec. 1203.1B.2.d.3

Added "Please refer to Medicaid Services Manual Chapter 3600 for information on Managed Care Organizations."

Deleted "Contact instructions are noted on each recipient's Medicaid card."

Sec. 1203.1E

Added "PA requests may be done via phone, fax or via FHSC's Web PA."

Sec. 1203.1E.1

Added "requesting a"

Deleted "completing the"

Added ","

Sec. 1203.1E.1.c

Added "within 24 hours of receipt"

Deleted "must sign the PA and forward all copies to the QIO-like vendor. He/she"

Added "on faxed PA requests."

Deleted "by return copy"

Deleted "("

Deleted ")"

Sec. 1205.3

Deleted "Email: nevadamedicaid@fhsc.com"

APPENDIX A-TABLE OF CONTENTS

Added "(PPI's)"

Deleted "II"

Added "2"

Deleted "DURAGESIC (fentanyl transdermal) PATCHES....9"

Added "LIDODERM 5% PATCHES®....20"

Deleted "INHALED INSULIN....11"

Added "OMALIZUMAB (Xolair®)....21"

Deleted "(recombinant human growth factor)"

Deleted "SEE TABLE FOR"

Added "NARCOTIC/ACETAMINOPHEN COMBINATIONS....23"

Added "R"

Added "® PALIVIZUMAUB"

APPENDIX A

Added "Duodenal/"

Deleted " (PUD)"

Added "/Gastrojejunal"

Deleted "or"

Added "GI Hemorrhage, or Other Disease States"

Deleted "Inhaled insulin Inhaled insulin is a covered benefit for Nevada Medicaid for adult

Added "/Gastrojejunal"

Added "g."

Added "Children aged 5 years and younger"

Added "Therapeutic classes"

Added "(PA)"

Added "(POS). Or the PA requirement will be overridden for anticonvulsant medications when the prescriber has a provider specialty code of 126, neurology or 135, pediatric neurology, in the POS system."

Added "(PA)"

Added "(POS). Or the PA requirement will be overridden for anticonvulsant medications when the prescriber has a provider specialty code of 126, neurology or 135, pediatric neurology, in the POS system."

Added "o"

Added "R. Lidoderm 5% Patches® 1. Coverage and Limitations Topical Lidoderm Patches® are a covered Nevada Medicaid benefit for recipients who meet the criteria for coverage. Authorization will be given if one of the following criteria are met and documented: a. If an ICD-9 code beginning with 053., herpes zoster, is documented on the prescription OR b. Completion of a Generic Nevada Medicaid Request for Prior Authorization documenting a diagnosis of Post Herpetic Neuralgia/Neuropathy. Quantity Limits: a. Maximum of 90 patches per rolling 30 days."

Added "S. Omalizumab (Xolair)® 1. recipients (18 years or older) who meet the criteria for coverage. Coverage and Limitations: Authorization will be given if the following criteria are met and documented: a. Type 1 Diabetes Mellitus 1. Have an inability to self administer injections of SC insulin or has a persistent fear of self administration of SC insulin and do not have a caregiver who can administer SC insulin, or 2. Intolerance to SC insulin (e.g. allergic reactions, injection site reactions) 3. And the required diagnosed exclusions and laboratory criteria below are met. b. Type II Diabetes Mellitus who meet all of the following: 1. Unresponsive/intolerant to treatment with lifestyle changes 2. Unresponsive/intolerant have contraindications to at least two oral hypoglycemic within at least two separate therapeutic classes in any of the following classes. Note that a biguanide (e.g. Metformin) must be one of the agents attempted/tried or contraindicated. a. Oral sulfonylureas b. Biguanides c. TZDs d. Meglitinides e. Alpha Glucosidase inhibitors 3. Intolerance or contraindications to SC insulin (e.g. injection site reactions or allergic reaction) or inability to self administer insulin or has a persistent fear of self administration of SC insulin and without a caregiver who can administer insulin. c. Inhaled insulin is contraindicated in recipients with the following conditions and will not be approved: 1. Current smokers 2. Patients who have discontinued smoking within the last 6 months (date of discontinuation must be verified). The patient must be completely free of smoking activity for at least 6 months for approval to be considered. 3. Patients with underlying lung disease (e.g. asthma, COPD) d. The following laboratory criteria must be met: 1.Documented PFTs prior to initiation of therapy: (if not done then inhaled insulin will not be authorized) 2. FEV1 or DLco must be greater than or equal to 70% of predicted 3. FEV1 or DLco must be done after 6 months of therapy and then annually, at each subsequent measurement if there has been a confirmed decline of 20% of FEV1 from baseline then inhaled insulin will not be authorized."

Coverage and Limitations Omalizumab (XOLAIR)® is a covered Nevada Medicaid benefit for recipients who meet the criteria for coverage. Omalizumab has not been shown to alleviate asthma exacerbations acutely and should not be used for treatment of acute bronchospasm or status asthmatics. Authorization will be given if all of the following criteria are met and documented: a. Recipient must have a diagnosis of moderate to severe persistent asthma. b. Recipient must be 12 years or older. c. Recipient must have tried or have a contraindication to inhaled oral corticosteroids. d. Recipient must have tried or have a contraindication to an oral second generation antihistamine. e. Recipient must have tried or have a contraindication to a leukotriene receptor antagonist. f. Prescriber must be either a pulmonologist or allergist/inmmunologist. g. Recipient must have a history of a positive skin test or RAST test to a perennial aeroallergen. h. Recipient must have had a pretreatment serum total Immunoglobulin E (IgE) level. i. Recipient's current weight must be recorded. Prior approval will be granted for a three month period."

Added "PA Form: Generic Nevada Medicaid Requests for Prior Authorization Form. PA forms are available at http://nevada.fhsc.com."

Added "B. Narcotic/Acetaminophen Combinations Includes all strengths and dosage forms of: a. Propoxyphene/ Acetaminophen Cominations b. Oxycodone/ Acetaminophen Combinations c. Meperdine/ Acetaminophen Combinations d. Pentazocine/ Acetaminophen Combinations e. Hydrocodone/ Acetaminophen Combinations f.

Deleted "1. PA Guidelines: PA Form: Generic Nevada Medicaid Requests for Prior Authorization Form. PA forms are available at http://nevada.fhsc.com."

Deleted "a. Children ages 5 years and younger"

Deleted "Psychotropic medication categories and medications"

Deleted "Treatment for seizure disorders with the following diagnoses"

Codeine/ Acetaminophen Combinations g. Dihydrocodeine/ Acetaminophen Combinations h. Tramadol/ Acetaminophen Combinations i. OTC Acetaminophen 1. Coverage and Limitations: Any dosing which amounts to greater than 4 grams of acetaminophen per day will NOT be covered."